"Please God Help Me"

The nursing home failed to ensure staff followed and implemented abuse and neglect policies and procedures for reporting, investigation, and protection for residents 60, 115, and 104. Additionally, the nursing home failed to investigate and protect residents from retaliation and further abuse and neglect after reporting concerns to the Resident Council.

The nursing home's failure to immediately report allegations of abuse and neglect to the state agency as required, failure to initiate immediate investigations, and failure to protect residents after an allegation of abuse/neglect constituted a situation of Immediate Jeopardy. Residents 60 and 104 suffered psychosocial harm in the form of fear, feeling abandonment/neglected and experienced retaliation from staff.

During a Resident Council meeting, residents reported they are afraid/not comfortable reporting individual staff members, when staff does/says something inappropriate to them, ***due to the retaliation they have experienced, have witnessed, or their peers have stated, when they have asked for their preferences to be met, or assistance they needed. They stated that most of the staff members respond to them as if they have no awareness of residents' rights.

The residents were upset that their call lights are not being answered in a timely manner, mostly on the evening and night shifts, and are afraid to say anything about the staff, due to *** above. They reported that staff is rude to them, ignore them, laughs at them, do not take them seriously, accuse them of asking too much of staff, and that even co-worker friends treat them badly when they have spoken up for themselves. Overall, the residents do not feel heard, and supported in their numerous attempts to have their needs and preferences met. The residents stated that Genesis (corporation) does not care about them.

During an interview with two surveyors, resident 60, who had intact cognition and needed two-person assistance with activities of daily living, reported an allegation of neglect. The resident stated that one Sunday ago, around 1:00 PM to 2:00 PM, she called for help as she had a loose bowel movement and needed to be changed. Staff N answered her call light, told her he would be back but never returned. The resident stated she was not changed until 8:00 PM that day. The resident stated, "I felt neglected. I was crying the whole time I was waiting. I said to myself, 'Please God help me and have somebody come.'"

Resident 104 was alert and oriented and able to make her needs known and assessed to be dependent on staff for care, requiring two-person extensive assist for transfers and toileting. During an interview, while visibly upset and crying, the resident stated she used the call light to request assistance to have her incontinence brief changed but "sat in my wet brief for at least an hour to an hour and 15 minutes." Review of Grievances Log included a statement by resident 104 by which grievances given to CNAs result in retaliation. She stated that she is forced to wait more than 2 hours and feels punished.

Name of Nursing Home	Ballard Center / Provider ID: 505042
Address	820 Northwest 95th Street, Seattle, Washington
Date investigation completed	November 7, 2018
Type of deficiency issued	F607 – Develop/Implement Abuse/Neglect, etc. Policies
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/505042/health/standard?date=2018-11-07